STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING _____ B. WING _____	C 09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	**2200 N RILEY HWY SHELBYVILLE, IN 46176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for Investigation of Complaint IN00115113. Complaint IN00115113- Unsubstantiated due to lack of evidence. Survey Date: September 18, 2012 Facility number: 004268 Provider number: 155735 AIM number: 200504460 Survey Team: Courtney Mujic, RN-TC Beth Walsh, RN Karina Gates, Medical Surveyor Census Bed Type: SNF: 20 SNF/NF: 26 Residential: 27 Total: 73 Census Payor Type: Medicare: 10 Medicaid: 17 Other: 46 Total: 73 Sample size: 3 Ashford Place Health Campus was found to be in compliance with 42 CFR part 483 subpart B and 410 IAC 16.2 in regard to the investigation of complaint IN00115113. Quality review completed 9/18/12	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Cathy Emswiller RN	F 000		